No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L. AND JOYCE CRUZAN,

Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents,

v.

THAD C. MCCANSE, GUARDIAN AD LITEM,

Respondent,

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF NURSES FOR LIFE OF MISSOURI AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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MOTION FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE ON BEHALF OF RESPONDENT

Amicus hereby respectfully moves for leave to file a brief amicus curiae in the present case. Requested consent of parties is expected but has not yet been received and filed. When filed, it will make this motion unnecessary.

INTEREST OF AMICUS CURIAE

Nurses for Life of Missouri is an organization of 700 nurses in the State of Missouri. We believe that an ounce of experience can be worth a pound of theory. The unfortunate Nazi and early Stalinist Russian experiences were not in a democratic nation, but the Netherlands is a democratic nation and the defects in the brave new euthanasia world in the Netherlands frighten us. This brief is taken in large part from Issues in Law and Medicine Vol 4 #4 (1989).

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SUMMARY OF ARGUMENT

If the allegations of the present brief are correct and, for example, 93% or 95% oppose euthanasia from among those elderly most likely to exercise a right to euthanasia by substituted judgement, what is the benefit of reversing? In the Netherlands, depending on question phrasing 93% or 95% of the most likely beneficiaries [who apparently feel threatened, not desirous] oppose euthanasia. If the poll results are incorrect, Petitioners will have an opportunity to say why. The Court should not without good reason dismiss these polls because they have been made public both in the Netherlands and in the US for some time, and if incorrect should have been previously disproved. It is results like these which have caused every State legislature to refuse to grant the change

in the law which petitioners and their amici seek to have imposed on America as an unenumerated US Constitutional Right by this Court acting as a Super Legislature.

Because of the nature of this Court's defects as an information gathering and checking agency and an inability to subpena witnesses or records, this Court will have to rule without knowing if 93% of Dutch nursing home patients oppose euthanasia. Because of the nature of the appellate procedure, and everyone's inability to predict the future, this Court cannot know if reversal would duplicate in America defects alleged herein in the Netherlands. This points to the wisdom of not reversing and permitting this issue to be decided by the legislatures which have advantages this Court lacks, including deciding on

the basis of better information, fact finding ability, ability to learn from experience and experiments, and flexibility in that it is far easier for legislatures to correct or fine tune a law. If the Court wrongly reverses, it will do serious damage to America and initiate a battle more bitter than the abortion battle. If the Court wrongly refuses to reverse, time will so indicate and there will be later opportunities to achieve the same result, only better fine tuned because more information will then be available and with less likelihood of a bitter battle, because the dispute in the States will not have been preempted prematurely by this Court.

Much of this brief has been taken from ISSUES IN LAW & MEDICINE Vol 4 #4, Spring, 1989 "Euthanasia in the Netherlands: A Model for the United

States?" by Barry a Bostrum, JD, with translations by Dr Walter Lagerwey, Queen Juliana Professor of Dutch, Emeritus, Calvin College, Grand Rapids, MI.

Russia abandoned euthanasia after a six month test in 1922 [MD Aug 1989 p 73]. Nazi Germany also tried it. The Dutch experience indicates the trouble with euthanasia relates inherently to euthanasia, rather than to the fact that Germany and Russia were dictatorships. Public opinion, except for elderly likely beneficiaries [or as they see it victims] is split. The legislature never legalized it. It was legalized by the courts refusing to enforce existing sanctions and acting as a super legislature to define rules. The AMA equivalent medical association then published guidelines. Euthanasia then was extended and extended similar to what might happen here.

EUTHANASIA IN THE NETHERLANDS

The euthanasia debate has escalated dramatically in the United States over the past few years by court action in the absense of the passage of new laws by legislatures. What is commonly referred to as passive euthanasia has been sanctioned by many courts. Passive euthanasia is commonly understood to be the deliberate killing of the patient by acts of omission, such as the withholding or withdrawal of life sustaining medical treatment. In contrast, active euthanasia is commonly understood to refer to deliberate killing of the patient by acts of commission, such as lethal injection. Those who oppose euthanasia do not deny the moral and legal right of competent persons to refuse useless or excessively burdensome treatments. The key issue is whether the purpose of the act of omission or commission is to terminate the life of the patient. For this reason, much opposition arises from the inclusion of nutrition and hydration in the category of medical treatment which can be refused. With the exception of persons who have an imminent death expectation, or for whom nutrition and hydration are otherwise useless, the withdrawal of nutrition and hydration is an act of killing by omission. Usually it is done for the specific purpose of killing. If legitimized as an unenumerated US Constitutional Right, What might logically follow?

In previous years in the debate, passive euthanasia and active euthanasia have been distinguished in order to make passive euthanasia more acceptable to reluctant ethicists, physicians, lawyers,

and judges. However, once passive euthanasia is generally accepted, as in the Netherlands, the argument will be reversed to state that there is no ethical difference between passive and active euthanasia since both actions are intended to result in the death of the patient. Thus, active euthanasia is promoted as more humane, and the ethical equivalent of passive euthanasia. There will be no good argument against this step because the dike will have been breached and will have broken.

Although passive euthanasia for competent patients has been widely sanctioned in the United States, much debate has arisen concerning passive euthanasia for patients who are not competent to make medical treatment decisions. Two reasons are commonly used to justify passive euthanasia for persons

who are incompetent: the best interest standard and the substituted judgment standard. These standards permit guardians or family members to make decisions constituting passive euthanasia for persons found to be incompetent to make decisions for themselves.

Thus, the debate concerning active euthanasia has important implications both for competent and incompetent patients. Euthanasia is freely discussed in ethical, medical, and legal journals throughout the country. The articles appearing in these journals illustrate the controversiality and complexity of the medical-legal-ethical issues inherent in the subject, and which attorneys and courts are called upon to struggle with.

THE NETHERLANDS

This brief focuses on the Netherlands because it is the first post Nazi nation

to sanction active euthanasia. This fact means that the Netherlands offers a unique opportunity to assess the effects of sanctioned euthanasia upon law, medicine, and the health care of persons who are medically dependent and disable in a modern democratic nation. In essence, the practice of active euthanasia there constitutes a unique social experiment which can be analyzed by scholars native and foreign to that community of people. It offers proponents of euthanasia a living model to illustrate the advantages and disadvantages of sanctioned active euthanasia.

Two significant aspects of the Dutch euthanasia experiment as they relate to the practice of law and medicine are discussed: The first is the present official status of the law on the

practice of euthanasia. The second is the reality of the practice of euthanasia and its effects on the practice of law and medicine.

WHAT IS THE LAW IN THE NETHERLANDS?

The present legal status of the law on euthanasia in the Netherlands is complex. An exception to the Penal Code has been created by several court decisions. These decisions have set out certain guidelines which define the conditions under which acts of euthanasia will be excepted from the penalties of the Penal Code. Acts of euthanasia which do not conform to these guidelines are subject to prosecution and punishment.

Euthanasia and assisted suicide are defined in the Dutch Penal Code Articles 293 and 294 as follows:

Art. 293: He who robs another of life at his express and serious wish, is

punished with a prison sentence of at most twelve years or a fine of the fifth category [approximately 50,000 U.S. dollars].

Art. 294: He who deliberately incites another to suicide, assists him therein or provides him with the means,is punished, if the suicide follows, with a sentence of at most three years or a fine of the fourth category [approximately 12,500 U.S. dollars]. [DREISSE, 3 ISSUES IN LAW & MED 385, 386 (1988) hereafter Dreisse)]

The Royal Netherlands Association for the Promotion of Medicine (the Dutch abbreviation is KNMG) is the Dutch medical association. Together with nurses union, the KNMG in its Guidelines for Euthanasia defines euthanasia as "an action which aims at taking the life of another at the latter's express request.

It concerns an action of which death is the purpose and result." It is clear from these definitions that voluntary euthanasia as currently practiced by physicians in the Netherlands is a violation of the Dutch Penal Code.

The legislature has been unable to agree on a change to the Penal Code legalizing euthanasia, but the courts have created an exception to Articles 293 and 294 by refusing to uphold the convictions of doctors who have followed certain guidelines in performing euthanasia. These judicial guidelines have been expanded and refined by the KNMG in order to help doctors avoid investigation and prosecution.

The guidelines [Royal Netherlands Association for the promotion of Medicine and Recovery, Guidelines; reprinted 3 Issues in Law and Med 429 (1988)]]

published by the KNMG and nurses union require the following: (1) a voluntary request for euthanasia from a competent patient; (2) the patient must be fully informed of his medical condition and the alternative treatments, there must be no alternative treatment which will alleviate the patient's suffering; (3) the request must be persistent over a period of time (written documentation of the number and dates of the requests is helpful); (4) the patient's suffering must be persistent, unbearable,and hopeless; and (5) the doctor must consult with at least one colleague about the request of the patient. If a doctor follows these guidelines in killing a patient, he is practically immune from prosecution in the Netherlands.

The KNMG guidelines are conservative when compared to legislative proposals or

judicial decisions. However,it should be noted that the above guidelines do not require a terminal illness, an impending death, or a written request--safeguards which would be objectively verifiable.

An example of a government proposal is the "Proposal of Advice Concerning Carefulness Requirements in the Performance of Euthanasia" by the General Health Council. This proposal was introduced on March 26, 1987, and suggested the following requirements: (1) the doctors must inform the patient of the diagnosis, prognosis, and therapeutic possibilities; (2) the doctor and patient must be convinced the request for termination is voluntary without outside pressure; (3) the doctor may terminate an incompetent patient if there is a previously written declaration requesting termination, the doctor is convinced that

it was freely written, and there is no other solution for the patient's problem; (4) the doctor must consult with a colleague; (5) the doctor must make a report recording the above information and keep it for five years; and (6) if the patient is less than sixteen years old, termination may not take place before the doctor has informed the parents on the matter, unless the minor raises a valid objection to informing his parents. It should be noted that this proposal would permit termination of those persons (1) who are not terminally ill, (2) who are incompetent,and (3) who are less than sixteen years old without parental knowledge or consent. The proposal does not require a condition of unbearable suffering, terminal illness, or impending death.

Although the proposal of the General

Health Council is not as limiting as the KNMG guidelines,both are very limiting compared to the reality of euthanasia as practiced in the Netherlands.

WHAT IS THE REALITY?

The reality of euthanasia in the Netherlands is a multifaceted subject. In order to clarify these various facets of euthanasia and its influence on law and medicine, the discussion has been divided into seven parts: constantly expanding boundaries, the uncontrollable nature of euthanasia, fear of involuntary euthanasia, a change in attitudes, coincidental reduction of public health care benefits, the prosecutor's dilemma, and lack of Dutch consensus of opinion on euthanasia.

Constantly Expanding Boundaries

Although the KNMG guidelines and other proposals no doubt have influence

on the practice of euthanasia, the courts have actually set the guidelines for exception from prosecution under the Dutch Penal Code. These judicial guidelines have gradually broadened the categories of who may be killed by physicians without prosecution.

The first reported Dutch court opinion suggesting guidelines under which the termination of a patient may occur without prosecution is the February 21, 1973, opinion by the District Court Leeuwarden [3 ISSUES IN LAW & MED 429 (1988). This court set out guidelines, which, according to the assessment of the evidence by the court, were already widely accepted in Dutch medical circles. These guidelines state that the patient must have: (1) an incurable condition due to accident or illness; (2) unbearable physical or psychological suffering; (3)

stated his request to terminate life in writing; (4) begun the dying phase; and (5) the aid of a physician in his termination. The court went on to state that when all these conditions are met, life-shortening drugs may be used in order to alleviate suffering. The court drew a distinction between a gradual increase in medication in order to alleviate suffering, a side effect of which was the death of the patient, and a large dose of a drug given for the purpose of killing the patient. The doctor was convicted of administering a lethal dose "all at once" and sentenced her to a one week suspended prison sentence.

These conditions set out by the Leeuwarden court were very limiting and the boundary line drawn is much more limiting than even the KNMG guidelines.

It required an incurable illness, a written request,and a terminal condition. Even then, the drug treatment could not be such as to cause immediate death. However limited, this decision opened the door to active euthanasia as an exception to the Penal Code.

The most recent decision of note is the October 21, 1986, decision of the High Court of The Hague (the court of final appeal) [3 ISSUES IN LAW & MED, 445, 446 (1988)] in which it was declared that (1) the dire distress of a nonterminal patient in the advanced states of multiple sclerosis may justify the application of euthanasia; and (2) the mental duress of a physician may be an acceptable defense to prosecution for euthanasia.

H.R.G. Feber, Advocate General at The Court of Justice in The Hague, sums up

the current situation:

> "[T]he 'safe' terrain of physical suffering, which is almost always demonstrable and which everyone can sense, is abandoned for a murky area in which unbearable psychological feelings of displeasure are also going to be determinative in decisions with respect to euthanasia.

[3 ISSUES IN LAW & MED 455,461 (1988)]

Thus, candidates for euthanasia now include not only older persons, but youthful multiple sclerosis patients. Dr. Pieter V. Admiraal, noted euthanasia advocate, terminated the life of a young girl with multiple sclerosis. There was physical and psychological suffering, but no concrete death expectation. He was charged with committing an act of euthanasia. The charges were dismissed because his procedures fell within the

criteria developed by the High Court. [ID at 465] This is the same Dr. Admiraal who,one year after the dismissal stated publicly: "I always limit myself to that group of patients who are in the terminal phase of an incurable, usually malignant disease. . .[and] euthanasia occurs only as a last resort." Advocate General Feber concludes that "jurisprudence is considerably more progressive than the lawgiver--at least in the Trial Proposal--wants it to be." [ID at 465]

The future of this constant expansion of indications for euthanasia is illustrated by the following accounts. Dr. Sven Danner, of the Amsterdam Medical Center, where 75% of all Netherlands patients with AIDS are treated, reports that one in eight AIDS patients receive euthanasia. [De Telegraaf (Dutch newspaper) 4/3/87] Certain members of

Parliament fear that euthanasia will be regarded as a normal procedure for persons with AIDS. These fears arise midst reports that the public ministry and the inspector of public health have made certain "working agreements" for cases in which patients with AIDS request euthanasia and the physician involved concurs. [ID]

Furthermore, the majority of the State Commission on Euthanasia already supports involuntary euthanasia for persons who have irreversibly lost consciousness. Nurses at the University Hospital of Amsterdam terminated several comatose patients without any form of consent, even from the attending physicians. They were subsequently convicted, not for acts of euthanasia, but for acting without the guidance of a doctor, as required by the judicial

guidelines. [3 ISSUES IN LAW & MED 371, 377 (1988) hereafter Schepens)] In this way, there is a constant pressure on the judiciary to expand the circumstances and populations for which voluntary or involuntary euthanasia will be permitted.

THE UNCONTROLLABLE NATURE OF EUTHANASIA

Official death registrations in the Netherlands indicate that three thousand persons per year are terminated by doctors on the patient's request. [ID 374] This official figure is acknowledged to be low because thousands of acts of euthanasia are never reported due to the routine falsification of death certificates by doctors who wish to avoid investigation and prosecution. [3 ISSUES IN LAW & MED 467, 468 (1988) (hereafter Feber)] Other estimates range from five thousand to twenty thousand killings per year out of a total of 125,000 annual

deaths.

The only possible conclusion which may be drawn with certainty is that no one knows how many acts of voluntary or involuntary euthanasia are occurring. C.I. Dessaur, ead of the Department of Criminology at Nymegen Unversity, the Netherlands, states that there is no reason to assume that a revision of the Penal Code to permit voluntary euthanasia would not be as massively violated as the existing law. Dutch attorney, Marian H.N. Driesse states:

> At the time when the law which legalized abortion became operative, the practice was already much further along than the lawgiver had ever intended. And this development continues all the time. It is not possible to set the door ajar. The practice of legislation relative to

induced abortion has again demonstrated that. Then there were also warnings that the legal regulation of the grounds for justification would have a stimulating, rather than a slowing, effect in practice. At that time, one could still assume that the parliament did not see through the consequences of legalization, but to believe now that even a Trial Bill could do any good in affording legal protection to the patient or the doctor--the seeing must be blind and the hearing must be death. [DREISSE 397]

Euthanasia is too easily performed and too easily concealed to be subject to any reasonable safeguards. Abuses can occur with impunity for the violators of the law. The situation presently

existing in the Netherlands is evidence that euthanasia is uncontrollable.

FEAR OF INVOLUNTARY EUTHANASIA AND OPPOSITION TO EUTHANASIA BY 93% OF ELDERLY

The uncontrollable nature of euthanasia has been perceived by many and has resulted in a fear of involuntary euthanasia. In a recent study of the views of older persons on the subject of euthanasia, it was determined that 93% of the persons interviewed in Dutch nursing homes were opposed to euthanasia, and 95% were opposed to legalization of euthanasia. [SEGERS, OUDERN OVER EUTHANASIE (ELDERLY PERSONS ON THE SUBJECT OF EUTHANASIA (1987) 3 ISSUES IN LAW & MED 407, 418 (1988) (hereafter Segers)] Fifty to sixty percent of the older persons interviewed were fearful of involuntary termination.[ID 422] Three

quarters of the nursing home residents and nearly one half of those older persons living independently were absolutely opposed to others (including family members and their treating physician) making decisions concerning termination of their lives if they are incompetent to decide for themselves. [ID 424]

Sociologist, Dr. H. Hilhorst, based on his research in Dutch hospitals, states: "Nurses and doctors say that the family more frequently requests termination of life than does the patient himself. An occasional doctor even relates that the family has put pressure on him to end the suffering and life of the patient." [C DESSAUR & C RUTENFRANS, MAG DE DOKTER DODEN? cited in Press information on the Final Report of the Sate Commission on Euthanasia 8/19/85 at

4 (hereafter Dessaur)]

Hilhorst also concludes that not only the family, but also the nursing personnel and doctors often put pressure on the patient to request euthanasia. [ID at 76]

Dr. Fenigsen, a Dutch cardiologist, has remarked that, as a rule relatives request euthanasia because they say the patient can't tolerate any further suffering. He continues, "They honestly believe this. . . They do not realize that they themselves can no longer tolerate the situation." [R FENIGSEN, EUTHANASIE: EEN WELDAAD? (A BLESSING?) 68 (1987)

In 1973, Dr.J. Michels wrote that for most terminally ill patients, "the discussion about euthanasia is a threat, they do not feel safe in our hands any longer." The situation has degenerated

to the point that a patients´ union has been organized under the name "The Netherlands Patients Organization")(De Nederlandse Patientenvereniging). [DESSAUR 79-80] Its activities include the warning of sick people and their families that in many hospitals people are being killed without their consent and knowledge, and even without the knowledge of their families. [ID 80] The Hiding Place Foundation (Stichting Schuilplaats) has recently issued a "life declaration," a small document to be carried on one´s person stating that the undersigned does not wish to have euthanasia practiced on him. [ID 80] Such a document is only needed, of course, if people believe that involuntary euthanasia is being practiced.

One example to demonstrate why older persons and terminally ill persons have

reason to be fearful of involuntary euthanasia is the 1985 case involving a De Terp doctor. Twenty-one suspicious deaths were revealed during an investigation. The doctor confessed to killing five older persons by injecting insulin. He was eventually convicted of killing three older persons. A voluntary request for euthanasia could not be proven. The doctor received a one year unconditional prison sentence. The KNMG (Netherland´s medical association) and others criticized the judgment as too strict. The president of the KNMG declared: "I fear that this judgment can lead to euthanasia practice again being drawn into the sphere of secrecy." [ID 113-115]

Attorney General Remmelink states: "The legitimation of the killing of people who are not yet dying is an

extremely risky matter, because it offers the possibility--it is an exaggeration to put it this way--that weaklings, frivolous people and criminals in the medical profession and the nursing profession (and such elements are undeniably present in these professional groups in numbers that one cannot ignore) can kill people without there being a reasonable chance that judicial action can be taken against them. . ." [3 ISSUES IN LAW & MED 445, 446] For the Attorney General, as well as others, the uncontrollable nature of euthanasia directly results in a fear of involuntary euthanasia which is impossible to prosecute.

A CHANGE IN ATTITUDES

Another aspect of legalized euthanasia is the effect of euthanasia in practice on the attitude of physicians

towards patients who are very disabled by illness or accident,but do not meet the guidelines for euthanasia. The power to make decisions to actively terminate life, once accepted and exercised, tends to generalize to broader categories of patients. This in turn effects a change in the attitude of patients toward physicians.

First, the change in attitude is illustrated by the phenomenon of useful treatment procedures omitted by decision of the doctor without knowledge or consent of the patient. Dr. Fenigsen, a Dutch cardiologist, cites the following examples from his own experience:

A young female doctor expresses objections to the use of pacemakers in people older than seventy-five years and declares that society should not be burdened with the duty of keeping old

people alive.

A team of anesthesiologists in a university hospital decides to deny anesthetics to children with Down Syndrome in operations for congenital heart defects making such operations impossible.

A chef-cook at a hospital appears to be suffering from uremia (blood poisoning resulting from kidney failure). An internist rejects him for dialysis and allows him to die because 'the patient is an unmarried single person.'

A colleague and internist refers a patient with a myocardial infarction and lung edema to me and states that this man 'is not to be saved too energetically because he is a lonely widower.'

A house doctor sends two ladies to our hospital, both with acute lung edema (a sudden collection of fluid in the

lungs which is frequently a fatal condition, however,it can often be relieved quickly), and both times the doctor insists, by telephone, that the hospital refuse to assist these women who, in his judgment, are too old,and (in the case of the second) that the hospital also refuse admittance. [DESSAUER 399-403]

Dr. Fenigsen states that this phenomenon is well known in medical circles and well published. [FENIGSEN AT 87]

Second, the change in attitude is reflected in the pressure put on patients to voluntarily request euthanasia. Pro-euthanasia doctors in hospitals persuade patients who are critically or terminally ill to request euthanasia by portraying vividly the suffering to come and the "gentle way out." The patient

may be driven to despair, become deeply depressed, and in that state of mind request termination. Once the decision is made, it is very difficult for the patient to change his mind because such equivocation is embarrassing to the patient the patient's family. [ID 64-65] One may legitimately question whether such a request is voluntary.

Third, the change in attitude is evident in the selection process for hospital ethics committees. Since euthanasia is a regular item on the agenda, doctors who oppose euthanasia in principle are not welcome. In order to avoid constant debate and division of opinion, only doctors who favor euthanasia are selected. The committees are in effect proponents of euthanasia, who consider killing permissible, who are attracted by the reasonableness of

euthanasia, and who believe the practice of euthanasia is part of the physician's calling. Such committees are popular because they relieve individual doctors of potential civil or criminal liability and promote the image of careful consideration of each request for euthanasia. [ID 73]

Dr. Fenigsen concludes: "The old certitude that the doctor is someone who will do everything possible to save a sick person, who will not neglect anything that can be of use, who will certainly do nothing to harm the patient, no longer exists." [ID 87]

COINCIDENTAL REDUCTION OF PUBLIC HEALTH CARE BENEFITS

At the same time that euthanasia is receiving so much attention in the Netherlands, there is a coincidental reduction of public health care benefits

for the care of older persons. Extensive reductions are being made in public health care funding without investigation of the effects upon the health of older persons. [SEGERS 409] Could it be that the engine for euthanasia is economic or polital instead of humanitarian? These funding reductions are occurring simultaneously with a growing population of older persons.

Dr. D. Kroon, a physician, describes the situation: "The government requires every hospital to have a medical-ethical commission to give advice when there are requests for euthanasia, and that while in many hospitals there is not even a functioning pain team. Coordinated discussion of how to combat pain is not possible here. It is possible to discuss the matter of permitting euthanasia, but there is no practical research into

alternatives." [ID]

As to the effect of such cut backs in public health care funding on requests for euthanasia, Dr. Kroon states:

> "There is an obvious need for more research here, especially when we see these developments against the background of the increase in the number of requests for euthanasia. To what extent are requests for euthanasia on the increase because adequate care is no longer being provided for the elderly? The abovementioned research by the Stichting Schuilplaats demonstrated that requests for euthanasia were definitely influenced by the kind of care being received. Acccording to this report, the kind of care required to cause requests for euthanasia to disappear include:

> nearness, showing understanding, listening, an optimal number of contacts, a good doctor-patient relationship, and effective combating of physical symptoms." [ID 409-410]

Certainly euthanasia appears to be an economical way to dispose of older persons who require a disproportionate share of health care resources. And once the health care benefits are reduced, causing a reduction in quality of health care, requests for euthanasia rise. Thus, the number of "voluntary" requests for euthanasia increase due to the poor quality of care older persons are receiving. In this way the engine for euthanasia is readily fueled in the Netherlands.

THE PROSECUTOR'S DILEMMA

Every year there are thousands of violations of the Penal Code prohibiting

euthanasia, but only a small fraction of these violations are even brought to the attention of the Public Prosecutor. [FEBER 467] One reason is that doctors regularly falsify death certificates in order to conceal euthanasia as the cause of death. H.R.G. Feber, Advocate General at The Court of Justice in The Hague, the Netherlands, states: "The medical profession is in all likelihood the only academically trained group of professionals, who by virtue of their profession are guilty of making false statements in writing with great regularity when after a euthanasia procedure they make inaccurate death declarations which conceal the unnatural death cause.

Another reason why only a very small percentage of violators are prosecuted is the difficulty of deciding which cases

can be successfully prosecuted. Since the exceptions to the Penal Code are judicially created,the decision to prosecute has fallen into the jurisdiction of the five attorney generals at the courts of justice. Meeting under the Secretary-General of the Ministry of Justice, they give a final verdict on every euthanasia case which is brought to the attention of the Public Prosecutor. [ID] Among the medical-legal issues to be decided are the following: (1) whether the euthanasia act committed by the accused would, from an objective medical perspective, be regarded as an action justified as a situation of necessity; (2) whether the further progress of the illness would still allow the patient to die with dignity; and (3) whether there were alternatives for the alleviation of the

victim's suffering. [ID 458] Only if the above questions and others of similar complexity are answered by the attorney generals in the affirmative is a case prosecuted. For any number of reasons, many violators are never prosecuted. In this way the attorney generals and Public Prosecutor are forced into the role of a pseudo-legislator, determining the extent of the euthanasia exception to the Penal Code. [ID 467]

Due to the false testimony of many physicians, the Public Prosecutor has not been overwhelmed with cases. However, as doctors increasingly inform themselves about the carefulness guidelines (which must be met in order to avoid prosecution), and as doctors realize that most cases are never prosecuted, more doctors are reporting truthfully their acts of euthanasia, resulting in an

increasing number of euthanasia cases being reported to the Justice Department each year. This increase promises to become a flood tide in the foreseeable future, adding further pressure to the Public Prosecutor. [ID 468] Due to these circumstances violators of the Penal Code are seldom prosecuted.

NO DUTCH CONSENSUS OF OPINION ON EUTHANASIA

That there is no consensus of opinion on the practice of euthanasia is readily admitted, even by those who are proponents of euthanasia in some form. Attorney General Remmelink, in commenting upon a recent opinion from the High court, asks "whether one can really speak of a uniform medical ethic?" [3 ISSUES IN LAW & MED 445, AT 449 (1988)] He answers his own question by asserting that the answer is obviously "no" because there

are great differences of opinion on this matter. The High Court in its opinion stated, "it is evident that even in medical circles in the Netherlands there is no general agreement regarding the permissibility of euthanasia and the manner in which, and the conditions under which, it might be carried out." [ID 446] Advocate General Feber states that medical-ethical experts are by no means agreed on euthanasia. Even in the KNMG (Dutch medical association) there is no agreement on the permissibility of euthanasia. [FEBER 458] Dr. D. van Tol, a Dutch psychiatrist, in his dissertation De balannssuicide, writes: "The reality is that we cannot speak of prevailing norms in medical ethics with regard to self-killing. As far as ethical judgment regarding assistance in self-killing is concerned, the doctors are as divided as

the rest of society."

The opinions held by "the rest of society" are somewhat difficult to ascertain. Public opinion poll results vary. According to some polls 70% of all Dutch citizens and 70% of all Dutch doctors favor voluntary euthanasia. [FENIGSEN 95] Who the beneficiaries of euthanasia are to be is not always clear in the poll questions.

Other polls clearly target the populations to be euthanized. A January 13, 1986, poll reported that based on 801 persons interviewed, 33% has "much understanding" for active euthanasia, 43% wants active euthanasia for comatose patients, 38% wants active euthanasia for the incurably ill, and 27% deems it possible to request euthanasia for senile members of the family. Professor Dr. C.I. Dessaur, head of the Department of

Criminology, Nymegen University, makes the following observation about these poll results: "The ugly part of these figures lies in the fact that all the questions were concerned about involuntary euthanasia." [DESSAUR 29,quoting AVRO Dutch TV poll 1/13/86]

Another poll confused mercy killing, which is murder under the Penal Code, with active euthanasia of older, incurably ill patients. Thirty-three percent felt "very positively" toward mercy killing, and 44% felt "somewhat positively" for such acts. The questions contained no reference to voluntariness. [id 29]

These polls prove too much. Apparently there are many people who approve of involuntary euthanasia at a time when the medical-legal-political discussion concerns only voluntary

euthanasia. These statistics perhaps explain the research demonstrating that the vast majority (93%) of nursing home residents is opposed to euthanasia. [SEGERS 407, 420-424]

Since there is no Dutch consensus of opinion on whether euthanasia should be practiced, or under which conditions it should be permitted, parliament and the government have no intention of amending the Penal Code to permit it. This delay in amending the Penal Code follows the same pattern as the abortion revolution in that abortion was practiced freely for ten years before the law was changed. This political maneuver avoids direct confrontation and permits the courts freedom to act as pseudo-legislators in the absence of action by the parliament. Thus, attempts to revise the Penal Code are delayed until organized opposition

weakens in the face of societal acceptance over a period of years. [SCHEPENS 380-381]

The rationalization for this delay derives from the lack of consensus. The State Commission on Euthanasia states: "[I]t will take many more years before the desired clarity develops with regard to the limits of criminalization in regard to euthanasia." [DRIESSE 395] A letter from the Minister of Justice and the Minister of Welfare, Public Health and Culture, in which a revision of the law is opposed, states: (1) "[I]t cannot be posited that the legal pronouncements [on euthanasia] have crystallized sufficiently," (2) "creating room in the law [for euthanasia] can have as a result the consequence that there will again be a moving of the boundaries," and (3) "one may raise the question whether the

ideological, ethical, and juridical aspects of this important question have been considered sufficiently and matured sufficiently in the realm of politics and in society." [ID]

In this way the law becomes a as id did in the case of abortion, a reflection of the lowest common denominator of public opinion rather than a setting of legal boundaries based upon a rational system of principles

The Netherlands offers a unique opportunity to assess the results of sanctioned euthanasia upon law and medicine. When the results of that social experiment are analyzed, it is clear that the Netherlands experience is a model of that which is to be avoided, not followed.

The realty of euthanasia in the Netherlands is alarming. This is

reflected in the writings of physicians, jurists,and others who live there. The Netherlands may be touted as a model for the United States only by those who obscure that realty. Euthanasia is a dangerous concept because (1) the boundaries of such acts tend to include ever broader categories of persons medically dependent and disabled; (2) abuses are so easily concealed and so difficult to prosecute; (3) the effect is to diminish medical professionalism and efforts to save lives; (4) the acceptance is fueled by the convenience of reducing public health care costs at a time when the population of older persons is expanding; and (5) the fear of involuntary euthanasia grows creating a distrust of physicians and family members.

The primary motives which underlie

the present press for sanctioning active voluntary euthanasia seem to be (1) the fear of personal suffering; (2) prejudice and discrimination against persons who are older, ill, or disabled and whose quality of life appears to be so low that third persons decide they are not worth saving; and (3) pressure to reduce health care costs. None of the above motives justify the radical changes proposed in law and medicine. Instead, they must be recognized as pressures which distort rational decision making in health care.

The inadequacies of a myopic emphasis on an individual's "right to die" by legal scholars who favor the sanctioning of voluntary active euthanasia are exposed by the light of the realities of euthanasia in the Netherlands. Worst case scenarios prey upon our personal fears and seem to bolster the case for a

"right to die." But no one lives in a vacuum. Law, medicine, and health care should not be manipulated in order to satisfy some unprincipled version of constitutional rights for decision making in a worst case scenario. Instead, law, medicine, and health care should be designed to err, if at all, on the side of the preservation of life and the establishment of rational principles for the protection of the most vulnerable persons in society--those who are medically dependent and disabled.

The value of the Netherlands experience is not in the establishment of a right to die a dignified and humane death. The value is in providing an example illustrative of the perils of active voluntary euthanasia for society as a whole, and for each vulnerable person within that society. Certainly,

older persons and persons who are medically dependent and disabled deserve substantive and procedural safeguards to protect their rights to life,liberty,and property equal to those given to common criminals. A right to die, once accepted, too easily becomes a duty to die, or an excuse to kill. Euthanasia in the Netherlands is a notorious example of how unprincipled "humanitarian" intentions produce chaos in law, medicine, and health care.

CONCLUSION

This Court should look past the arguments and realize the ultimate consequences of sanctioning euthanasia. The Netherlands experience is a real life illustration of the effects of sanctioned euthanasia on society's most vulnerable persons. The split in opinion with those in age groups who would seek euthanasia

for their elders split, the vulnerable elders who would allegedly benefit being nearly unanimous in their opposition, the legislature never having acted, and the Pandora's box imposed on society by court decisions and part of the medical establishment has not yet played out to the end.

Respectfully submitted,

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NO 88-1503
IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L AND JOYCE CRUZAN
Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
Respondents,

v.

THAD C. McCANSE, GUARDIAN AD LITEM,
Respondent.

Affidavit of mailing of amicus brief copies, Rule 28.2

State of California }ss.
City of Santa Ana, County of Orange }

Robert L Sassone, being first duly sworn on his oath deposes and says:

Robert L Sassone is a member of the bar of the United States Supreme Court admitted October 26, 1971. To his knowledge, on October 11, 1989, within the particular time and permitted time for serving of said amicus brief pursuant to Rule 28.2, he deposited in the United States Mailbox at Santa Ana, CA 92701 pursuant to Rule 28.2 with first class postage prepaid 40 copies of the attached amicus brief in the present case properly addressed to the Clerk of the United States Supreme Court and three copies of said amicus brief to each party addressed as follows:

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Subscribed and sworn to before me on
October 11, 1989,

Lawrence D Sassone, Notary Public